Growth Hormone Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	RETAIL
IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here ☐	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐
• The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm

Drug for which Prior Authorization is requested: **Growth Hormone** _____

Step 1 **Please complete patient and physician information (Please Print)**

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Secure Fax #:

Step 2 **Please complete the clinical assessment**

1. Is the patient a child (<18 years old)?	☐ Yes Please proceed to question 5	☐ No Please proceed to question 2
2. Is the patient an adult with lowered growth hormone levels secondary to the normal ageing process, obesity or depression?	☐ Yes Coverage not approved	☐ No Please proceed to question 3
3. Is the patient an adult with growth hormone deficiency as a result of pituitary disease, hypothalamic disease, trauma, surgery, or radiation therapy, acquired as an adult or diagnosed during childhood?	☐ Yes Coverage approved for 1 year	☐ No Please proceed to question 4
4. Does the patient have Short Bowel Syndrome or Acquired Immunodeficiency Syndrome (AIDS) wasting or cachexia?	☐ Yes Coverage approved for 1 year	☐ No Coverage not approved
5. Is the patient a child with non-growth hormone deficient short stature (Idiopathic Short Stature)?	☐ Yes Coverage not approved	☐ No Please proceed to question 6
6. Is the patient a child with growth hormone deficiency, Turner's Syndrome, Prader-Willi Syndrome, chronic renal insufficiency (or other known renal indications) or a child born small for gestational age whose epiphyses have not closed?	☐ Yes Please proceed to question 7	☐ No Coverage not approved
7. Has the patient been evaluated by a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	☐ Yes Coverage approved for 1 year	☐ No Coverage not approved

Step 3 **I certify the above is correct and accurate to the best of my knowledge** (Please sign and date)

_____ _____

Prescriber Signature Date

Latest revision: July 2005